TRADITIONAL ACCESS (FFS) PLAN

BENEFIT	COST SHARING
Deductible	Single $400 Family $800
Maximum Out-of-Pocket for Covered Expenses After Deductible	Single $1500 Family $3000
Co-insurance	As Indicated Deductible Applies*
Lifetime Maximum Benefit	Unlimited
In-Hospital Care - Authorized Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal	15% Co-insurance*
Ambulatory/Hospital Outpatient Surgery	20% Co-insurance*
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, Small Bowel)	15% Co-insurance*
Out-Patient Services - Provider Office Visit, Office Diagnostic and Allergy Testing, Allergy Serum and Injections, Diabetes Education and Therapy, Radiation, Chemotherapy, and Dialysis	20% Co-insurance*
Maternity Care - Prenatal, Labor, Delivery and Postpartum (Pregnancy of Dependents Covered Same as Spouse Pregnancy)	15% Co-insurance*
Emergency Services - Hospital Emergency Room (Co-insurance Waived if Admitted) & Ground Only Ambulance	20% Co-insurance*
Urgent Care Treatment	$25 Co-payment
Preventive Services:	
Immunizations	10% Co-insurance
Well Child and Adolescent Care (0-18 years) - Age and Periodicity Limits May Apply	Office Visits Covered for Ages 0-18 years No Co-insurance/No Deductible
Well Adult Care - Age and Periodicity Limits May Apply	Routine Physical Exam and Specified Testing No Co-insurance/No Deductible
Mental Health:	
Inpatient	20% Co-insurance*, Maximum 21 days/plan year and 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)
Outpatient	20% Co-insurance*, 20 visits per Plan Year
Autism - $500 Monthly Benefit for Children Ages 2 through 21 years of Age for Therapeutic, Respite and Rehabilitative Care	Co-insurance Applicable to Service Provided*
Substance Abuse:	
Inpatient	20% Co-insurance*, Maximum 21 days/plan year and 1 admission/6 months (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)
Outpatient	20% Co-insurance*, 20 visits per Plan Year
Prescription Drugs and Oral Contraceptives	20% Co-insurance* - 30 day supply (Co-insurance Amount Does Not Apply Toward Satisfaction of Maximum Out-of-Pocket Limit)
Mail Order Service Pharmacy	20% Co-insurance* - 90 day supply

* Deductible Applies.

BENEFIT	COST SHARING
Physical Therapy	20% Co-insurance* 30 Visits per Plan Year
Occupational Therapy	20% Co-insurance* 30 Visits per Plan Year
Speech Therapy	20% Co-insurance* 30 Visits per Plan Year
Cardiac Rehabilitation Therapy	20% Co-insurance* 30 Visits per Plan Year
Osteopathic/Chiropractic Manipulative Treatment	20% Co-insurance* 20 Visits per Plan Year
Home Health Care	100 Visits per Plan Year Covered in Full*
Skilled Nursing Facility	20% Co-insurance* 30 Days per Plan Year
DME/Prosthetic Devices/Hearing Aids	20% Co-insurance*
Hospice	Covered in Full

The single and family deductible amounts may be either:

- A combined deductible for both medical and pharmacy services; or
- A split deductible with a set amount for medical services and for pharmacy services.

* Deductible Applies.